



Research Briefing

Behavioural prevention interventions in HIV

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A behavioural intervention is a method of changing behaviour, developed from empirically derived theories of behaviour and its determinants, that is applied to individuals and groups. It aims to first identify the factors which are most important in determining certain behaviours (e.g. under what conditions does it occur? What are the consequences? What makes it stronger or weaker?), and then attempts to alter some of these determining factors. This can be achieved through various methods such as changing the conditions that usually precede the behaviour, or providing alternative means of achieving the same beneficial consequence, or altering the perception of cost-benefit. The intervention must be evaluated to assess its efficacy, and must be open to scrutiny by others.

Behavioural prevention interventions have been utilised across a broad range of key socially relevant behaviours, including drug abuse, violence, mental health, and general health (smoking, cancer, sexual behaviour). Research has shown that for all prevention interventions to be most effective, across

any context, they must:

1. be comprehensive with multiple components;
2. involve varied teaching methods;
3. have sufficient dosage;
4. be based on evidence based behavioural theory;
5. promote positive and supportive relationships between key stakeholders (young people, peers, adults, etc);
6. be appropriately timed, and initiated early in peoples lives before they have established patterns of health behaviour;
7. be socioculturally relevant;
8. have clear goals and objectives and the outcome be evaluated;
9. have well-trained staff implementing the programme (Nation et al, 2003).

The task of any intervention is to identify the deficit within the individual or group through a needs assessment, and to design and deliver an intervention aimed to address the precise deficit identified.

A wide number of theoretical models have been developed to help predict sexual behaviour, with mixed levels of success (see Miller & Green, 2002; and Peterson & DiClemente, 2000 for summaries). Across most of the theories, some key common factors have emerged as crucial in the understanding of sexual behaviour. These include:

Information: how much people know about HIV and its prevention,

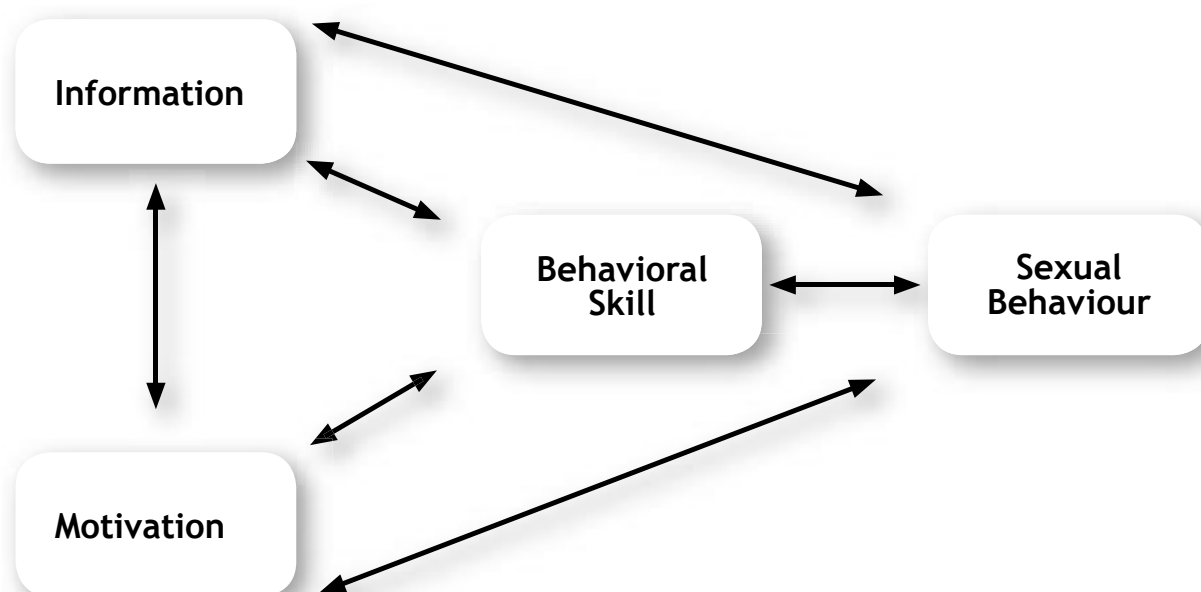
Behavioural skill: how able people are to successfully carry out risk reduction behaviours, and

Motivation: how much people perceive they are at risk of HIV and are motivated to become informed about and carry out risk reduction behaviours

For example, it may still be the case that certain individuals or groups within the UK are not well *informed* regarding the nature of HIV and how it is contracted and how it can be prevented. If this is the case as identified by a needs assessment, then an intervention needs to be developed to provide information and education around those issues. Knowledge is essential in helping people make decisions about their health, and this is the rationale behind most health promotion campaigns.

However, people may be well informed about HIV and be aware of what they need to do to protect themselves and others from HIV, but lack the *skills* necessary to implement these strategies. If a needs assessment identifies this as being a crucial deficit, then interventions need to be developed to help people become skilled

A framework for thinking about carrying out behavioural HIV prevention interventions within African communities in the UK (Fisher & Fisher, 1992)



in these health behaviours; how to obtain and use condoms, how to access health and information services and adhere to management and treatment plans developed for them, how to say 'no' or use a condom when their partner does not want to use one.

Individuals and groups may well be aware of the issues and may well be skilled in their ability to adhere to risk reduction behaviour, but they may not be *motivated* to do so. Do they perceive themselves to be at risk? How serious do they see HIV as being? What other priorities do they have that take precedence over adherence to safer sex strategies? Do they think that important people around them will disapprove of their desire to change their sexual behaviour? Will they be seen as 'uncool'?

The application of HIV prevention behavioural interventions

HIV behavioural interventions have been applied across a wide variety of populations and target groups worldwide. There have been many empirical reports of successful applications of HIV prevention behavioural interventions across a wide variety of populations and target groups, including groups of men who have sex with men, commercial sex workers, inner city populations, and people living with HIV (NIMH, 1998). However, most of this research arises from the USA; relatively little research has been conducted in the UK.

To date, the vast majority of the world's HIV prevalence lies within sub-Saharan Africa, and as a consequence there has been extensive development and evaluation of prevention interventions in that context. However, due to resource restraints, there has been very little in the way of robust evaluations of these programmes, although UNAIDS has produced a Best Practice Collection that summarises this cumulative experience.

There have also been a number of studies relevant to black and minority ethnic groups living outside of Africa, including those of African origin (Kalichman et al, 1999). These studies strongly support the use of behavioural interventions with African Americans and Latino's living in the USA (Shain et al, 1999).

There is increasing amounts of empirical evidence assessing baseline levels of sexual risk related knowledge, attitudes and behaviour in the overall African communities populations within the UK (see the Mayisha projects: Chinouya, Davidson & Fenton, 2001; Sadler et al, 2006), and within African people living with HIV within those communities (Chinouya & Davidson, 2003). There have also been a steady increase in the application of behavioural interventions to HIV prevention in African communities residing within the UK over the last 10 years, and while there is much anecdotal evidence to suggest that some of these interventions are appropriate and effective in bringing about significant changes in risk reduction (Pulle et al, 2004), there has been very little in the way of robust evaluation of these programmes in the UK (Prost, 2006).

Recent Evaluations

Recently there have been a number of academic papers written that attempt to provide an overview of the many studies carried out on the effectiveness of behavioural interventions for HIV. These meta-analyses have concluded that while prevention interventions clearly help people reduce their risk behaviour when they have already been diagnosed with HIV (Crepaz et al, 2006), HIV counselling and testing (VCT) on its own does not appear to be effective when applied to people who are not already infected (Weinhardt et al, 1999). This may well be because abbreviated VCT in a clinical setting is not able to dedicate the time to customise complex interventions around peoples individual circumstances. As King (1999) argues, the successful

population level changes in Thailand's sex workers and in USA gay men's and urban city heterosexual communities stem from behavioural interventions that formulate an understanding of the social contexts under which people appraise the health and the social priorities in their lives, and help people overcome and/or manipulate the powerful social forces (gender, power, economics, social desirability, and so on), that govern peoples behaviour. Identifying and managing peoples' motivation to change is so often the key.

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Key Websites

Centre for AIDS Prevention Studies; CAPS
<http://www.caps.ucsf.edu/capsweb>

Centre for HIV Intervention and Prevention; CHIP
<http://www.ucc.uconn.edu/~wwwpsyc/arrp1.html>

UNAIDS Publications
http://data.unaids.org/Publications/IRC-pub04/JC159-BehavChange_en.pdf
<http://www.unaids.org/DocOrder/OrderForm.aspx>

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